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Midyear Contractors' Meeting Held at Olympia's Boston Harbor- Forensic Evaluations of Veterans is Central Topic of Discussion

A select group of contractors met for a midyear meeting on a lovely summer day in the picturesque community of Boston Harbor, near Olympia. Pictured on the right are contractor therapists Bruce Harmon (left) of the King County Veterans Program, and Bill Johnson (center), who is the director of the veterans program for Compass Mental Health in Mount Vernon. Between them is Elissa Ashworth, wife of Clark Ashworth, (who is not pictured), WDVA contractor for Colville. The trio are conversing with WDVA Director John Lee, (right), and Lourdes "Alfie" Alvarado-Ramos, Deputy Director. The too brief visit of the WDVA officials served as a stimulus to speculate about future projects and a lively interest was expressed for the idea of producing a video that could be checked out from the local library on the readjustment challenges of veterans returning from deployment. As expected, many of the contractors' expressed concern was the mounting presence of the returning members of the Washington National Guard and reserve units after deployment to Iraq and Afghanistan. Contractors across the state are experiencing and increasing number of intakes involving veterans and family members. EE ##

Pictured on the left, basking in the bright summer sun while listening attentively with the sagacity of sages to the lively conversations among those assembled are (left to right) contractors Dennis Pollack of Spokane, Tom Wear of Seattle, and Dennis Jones of Mount Vernon's Compass Mental Health. ## (Photos by Flash and his self-focusing Kodak.)

Boston Harbor conferees gather in June 10 meeting from around the state to discuss veterans mental health services

Mount Vernon veterans therapist Bill Johnson listens with rapt interest to WDVA Director John Lee describing the support that the Department is giving to the PTSD Program. The June 10 conference was highlighted by spontaneous discussions of the conditions under which therapists are working with the states' veterans who are returning from combat deployment. Below is a similar scene picturing Tom Schumacher addressing the assembled (Bruce Harmon, Bill Johnson and Elissa Ashworth) on the nature of the repast about to be presented as luncheon. The sumptuous lunch was provided by Tom and his gracious wife, TJ Reinoso.

The consensus among the assembled contractors was that the Global War on Terror, particularly the war in Iraq, were disturbing older war veterans, leading to increasing irritability and sleep disturbance, and that the active young war veterans returning from deployments were difficult to engage in consistent ongoing psychotherapy. One of the issues that emerged from the discussion was that the Iraq War veterans were expecting to return for re-deployments in the near future and that those veterans showing posttraumatic symptoms were likely to experience an increase in symptoms as a result of spending more time in the combat zone. Contractors expressed sadness that veterans who already had PTS symptoms were required to redeploy to combat zones.

Contractors speculated about the various reasons Iraq and Afghanistan War veterans were difficult to initially keep in treatment. One issue was thought to be the wish that young war veterans have that their symptoms will remit spontaneously and they will escape the label and stigma of having a PTSD disability. Another apparent reason was that younger veterans are busy trying to restart their civilian lives, involving many in school and work, active marriages with young children, as well as ongoing National Guard and reserve training requirements. WDVA and King County contractors are attending State National Guard and reservist meetings to assist in the screening of veterans who are in need of counseling assistance. EE ##

Candid Pics of Contractors' Gathering

Gathered together in the sunny afternoon are (below) Federal Way King County Contractor Dorothy Hanson, host Tom Schumacher, and Renton King County contractor Bruce Harmon (also picture in a mug shot on the far right). The shed behind was built by Tom in his spare time, drawing on ancient Midwestern farm traditions. Below right is Centralia contractor Darlene Tewault. Not pictured here, but an important contributor to the discussions was Clark Ashworth of the NorthEast Counseling Center of Colville. ## *(Publisher Note:* Also not pictured is Emmett Early. It is the opinion of most contractors that Emmett suffers from *Raqaphotophobia*—the morbid fear of having one's picture appear in the *RAQ*. ts)

Portraits of Counseling Wisdom
(above) Renton Contractor Bruce Harmon and (below) Darlene Tewault, WDVA contractor in Centralia.

Above Dorothy Hanson of Federal Way is laughing, while Tom Schumacher and Bruce Harmon of Seattle confer

Pondering the profundities of the moment are contractors Tom Scherfinski of Olympia and Dennis Jones of Mount Vernon.

WDVA Deputy Director Lourdes (Alfie) Alvarado-Ramos and PTSD Program Director and the day's host, Tom Schumacher, confer.

Book Review:

Principles of Trauma Therapy: A Guide to Symptoms, Evaluation, and Treatment, by John Briere, Ph.D., and Catherine Scott, M.D.

Reviewed by Emmett Early

John Briere and Catherine Scott have produced a valuable textbook that can be considered a basic resource for psychotherapists in the field for the treatment of trauma disorders, and that is instructive for old timers as well as newcomers. The authors describe their work accurately as offering "a general philosophy of intervention that stresses a nonpathologizing, growth-oriented, and, ultimately, hopeful view of recovery from trauma" (p. 231).

Briere and Scott emphasize an inclusive approach to trauma theory and give ultimate respect to the healing power of the therapeutic relationship. They write in their conclusion: "We have outlined the range of interventions that are relevant to this process. At the same time, clinical techniques—although often providing great specificity and efficiency in treating posttraumatic stress—generally require an additional element: a caring, safe, and supportive therapeutic relationship in which the past can be explored and processed" (p. 231).

Briere and Scott give a general overview of the types of psychological traumas encountered in the modern world, and address the problem of combined and cumulative traumas. For the purposes of their book, they define trauma broadly. "Our own conclusion is that an event is traumatic if it is extremely upsetting and at least temporarily overwhelms the individual's internal resources" (p. 4). They examine the variables that make trauma disorders more likely and refer to Judith Herman, noting the "more existential impacts (that) include profound emptiness, loss of connection with one's spirituality, or disruption in one's ability to hope, trust, or care about oneself or others…" (p. 17).

The most useful sections of Briere and Scott's *Principles* concern the assessment and treatment of PTSD. They establish an excellent system of separating and highlighting their useful points, such as on page 41, in which they outline "general guidelines for assessment of trauma exposure." These outlines are most useful to novice therapists. They give an especially detailed and thorough explication of the variety of dissociative responses related to psychological trauma (pp. 53-55).

In their chapter on the "Central Issues in Trauma Treatment," Briere and Scott present their basic philosophy: "The approach that we advocate in this book emphasizes the probably innate tendency for humans to process trauma-related memories and to move toward more adaptive psychological functioning" (p. 67). They state "a second philosophical notion" that "trauma can result in growth" (p. 68). The authors restate the issue in terms of reframing: "By reframing posttraumatic symptoms as potentially adaptive, the clinician may counter some of the helplessness, perceived loss of control, and stigmatization that often accompanies flashbacks, activated trauma memories, or psychological numbing. In fact, clients who accept the reframing of flashbacks as trauma processing may even come to welcome some reexperiencing responses as evidence of movement toward recovery" (p. 92).

Aside from stating their philosophies of trauma and treatment, Briere and Scott support their statements and conclusions with abundant references to the current research.

The best aspect of *Principles of Trauma Therapy* for the working therapist is the concentration on the specifics of treatment. Briere and Scott describe psychoeducation, distress reduction and affect regulation, the details of cognitive interventions and emotional processing.

The Therapeutic Window

Timing is most important in treating the effects of psychological trauma and *Principles* gives the issue appropriate status with the concept of "working within the therapeutic window" (p. 77). The authors state "this usually involves adjusting treatment so that trauma processing that occurs within a level of distress—while, at the same time, providing as much processing as can reasonably occur."

To facilitate distress reduction and affect regulation, Briere and Scott review the therapist's arsenal of techniques, supplying helpful examples of each. For example, the authors discuss the technique of grounding when dealing with acute intrusion. This should be applied "only when clearly indicated, should be adjusted to the minimal level necessary to reduce the client's internal escalation, and should be framed in such a way that it does not stigmatize the client or over-dramatize the experience" (p. 96). They then present five specific grounding techniques, giving examples of each (pp. 97-98). They show how psychotherapy can increase the client's affect regulation capacity, which involves the perception and labeling of experienced emotions. "The critical issue here is not, in most cases, whether the client (or therapist) correctly identified a particular emotional state, but rather that the client explores and attempts to label his or her feelings on a regular basis. In our experience, the more this is done as a general part of therapy, the better the survivor eventually becomes at accurate feeling identification and discrimination" (p. 102). And through better identification of emotions, the client is able to better regulate emotional experiences. The authors then survey examples of specific tasks that serve to identify emotional triggers.

Briere and Scott then proceed to discuss cognitive interventions using Socratic method: "a series of gentle, often open-ended inquiries that allow the client to progressively examine the assumptions and interpretations he or she has made about the victimization experience" (p. 112). They ask the client to write about a topic related to the traumatic experience between sessions and bring it to the next session to read aloud. The authors emphasize that trauma-related cognitions should be treated as perceptions and assumptions that require updating, rather than being erroneous or pathological (p. 114). From this they proceed to assist the client in constructing a "coherent narrative" of the traumas.

(Continued on page 6, see *Principles*)

Book Review:

Stumbling on Happiness, by Daniel Gilbert

Reviewed by Emmett Early

Daniel Gilbert in his book *Stumbling on Happiness* searches through the annals of social psychology for a way of explaining the state of mind that defines happiness, but his efforts are a lot like the joke about the drunk who looks under the streetlight for his car keys, not because that's where he dropped them, but because that where there is light. By the time we finish his book, we don't really understand happiness, but we know a little more about how people think about the past and the future. We also are reminded of that entertaining professor we had for sophomore psychology class who kept the diverse classroom charmed with wit while he (or she) slipped in the facts. Dr. Gilbert is a Harvard College Professor of Psychology and *Stumbling on Happiness* is loaded with cleverness.

The title comes from his introductory quote from Willa Cather's *Le Lavandou*: "One cannot divine nor forecast the conditions that will make happiness; one only stumbles upon them by chance, in a lucky hour, at the world's end somewhere, and holds fast to the days, as to fortune or fame."

Dr. Gilbert's thesis aptly follows the quote. He asserts, and gives us evidence from psychological research, that imagination in humans has several shortcomings. One shortcoming is the "tendency (of the mind) to fill in and leave out without telling us" (p. 214). That is, our memory is flawed because it stores only bits of what we have learned, and we tend to be unconscious of the selectivity. In learning theory, I recall, there were three basic variables for recall: recency, salience, and primacy. We remember what happened most recently, the first experience in the order, and the experience that stands out. I can remember in high school that Brother Spooner cracked me up the side of the head in algebra class, but I cannot remember the axiom I was supposed to have memorized.

Which leads to the second shortcoming of the mind, according to Dr. Gilbert, which is the "tendency to project the present onto the future" (p. 226). Contemplating whether some future event will be pleasant or not depends largely on how we are feeling at the moment. We are much better off, Dr. Gilbert asserts, asking experts when it concerns planning for the future, rather than relying on our own imagination. Although, it is true, as Dr. Gilbert observes, "how we feel when we imagine an event is usually a good indicator of how we will feel when the event itself transpires" (p.119). What we don't know, in predicting the future, is what we don't know. Which leads to Dr. Gilbert's next point.

The third shortcoming of imagination "is its failure to recognize that things will look different once they happen—in particular, that bad things will look a whole lot better" (p. 227). This Dr. Gilbert attributes this to our tendency to rationalize and transform meaning.

Dr. Gilbert's thesis is that we as human's have minds that have spotty recall. We tend to be unaware that we have altered our own memories. He gives an example of one college color recall experiment: "Only 33 percent of the describers were able to accurately identify the original color. Apparently, the describers' verbal descriptions of their experiences (overwrote) their memories of the experiences themselves, and they ended up remembering not what they had experienced but what they had *said* about what they experienced" (p. 41).

So, for Dr. Gilbert, what was under the streetlight, when he was searching for happiness, was a series of psychology experiments. If he had been an anthropologist, he might have described groups of people who sustain happiness in spite of poverty, or if he had been a sociologist, he might have described how some people return to a normally happy state despite trauma and hardship. And if he were a meditation guru, he might talk about psychological states of mind that practice staying out of the future and the past and focus on the here and now.

Reading *Stumbling on Happiness* is a lesson in how one must take one's imaginings with a certain circumspection. We tend to remember the past with a bias. We might remember the house fire more clearly than the hours we spent in front of the fireplace reading poetry. Similarly, contemplation of the future is contaminated with the state of mind we are in at the present. When we get there, Dr. Gilbert, asserts, we will probably make the best of our situation.

The lesson here is that if we look long enough for our car keys under the streetlight, dawn will come and we just might find them. ##

RAQ Retort

The *Journal of Traumatic Stress* doesn't invite comment, but we do. If you find that you have something to add to our articles, either as retort or elaboration, you are invited to communicate via letter or Email. And if you have a workshop or a book experience to tout, rave, or warn us about, the *RAQ* may play a role. Your contributions will make a difference. Email the editor or Tom at WDVA.

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***Principles*, Continued from page 4.**

One of the rich aspects of Briere and Scott's *Principles of Trauma Therapy* is their efforts to show the similarities and compatibility between the various approaches, especially between cognitive-behavioral and psychodynamic psychotherapies. "The similarity and confluence between the notion of 'insight' and cognitive interventions is emblematic of the hidden similarities between many supposedly different therapeutic approaches. In this regard, most of the best therapies provide new information and the opportunity for new learning, often in the context of a supportive therapeutic relationship. Frequently, the issue is less what specific treatment is involved in this process than it is how well the client's access to—and integration of—new information is accomplished. The heavy-handed 'cognitive' confrontation of 'thinking errors' is probably as likely to be unsuccessful as is the ill-timed or disattuned use of depth 'interpretation' in psychodynamic treatment. On the other hand, a therapeutic approach that facilitates the client's growing knowledge (and coherent narrative) of himself or herself, both now and in the past, can have substantial impacts on his or her psychological recovery" (p. 119).

Emotional Processing

Briere and Scott give a central place in their book to the importance of emotional processing of trauma memories. Here they give special emphasis to the timing concept of the therapeutic window. They assert that "emotional processing occurs when exposure to trauma-reminiscent stimuli (either in the environment or as a result of thinking about or describing a traumatic event) (1) triggers associated implicit and/or explicit memories, which then (2) activate emotional responses initially co-encoded with (and conditioned to) these memories; and, yet, (3) the activated emotional responses are not reinforced in the external environment, or they are, in fact, (4) counterconditioned by opposite emotional experiences, leading to (5) extinction of the original memory-emotion association" (p. 122).

The authors give some excellent instructions (p. 131) for informing a client regarding the rationale for this therapy process, which they call "the crux of trauma work." They also acknowledge that there may be occasions when the client is overwhelmed and exceeds the limits of the therapeutic window. If this happens, they provide an ample discussion on "remediating window errors" (p. 137). When the therapy is done within the therapeutic window, the process of what they call "disparity" occurs. They write: "The processing of CERs [conditioned emotional responses] to trauma memories operates in a manner similar to the processing of fear in behavioral treatments for phobias. The ongoing activation of fear and other negative emotional responses during the repetitive recounting of traumatic material in the absence of any discernable, 'real' reason for such responses in the session means that such emotionality goes unreinforced. Eventually, responses that are not reinforced tend to fade" (p. 138).

One of the very helpful aspects of Briere and Scott's *Principles* is their abundant how-to detail in structuring trauma therapy. The end of their chapter on emotional processing presents a detailed timing of the therapy hour. When to introduce it, when to do it, and when to back off.

Therapeutic Relationship

The authors give extensive discussion to the issue of treating complex PTSD and the problems of identity confusion and disturbed relational functioning, usually based on early childhood abuse and neglect. Here they give warning to those therapists with busy travel schedules when they point out that the therapist must "be reliable enough to communicate stability and security" (p. 151). They give emphasis and credence to the therapeutic relationship as having an active healing component. "Far from being the nonspecific placebo effect or inert ingredient suggested by some advocates of short-term therapy, the relationship between client and therapist can be seen as directly and specifically curative" (p. 155). The authors have a wonderful phrase to describe therapist gaffs and blunders that threaten the therapy process. They refer to "momentary lapses in empathic attunement" (p. 156). These the authors take in stride in the spirit of therapeutic exposure to be processed and incorporated into the therapy work.

In the last chapters of their excellent textbook, Briere and Scott add a third author, Janelle Jones, to discuss treating the effects of acute trauma. Briere and Scott then broadly address the issue of the pharmacology of PTSD, which will no doubt be soon out of date, although their discussion of the biology of the HPA (hypothalamic-pituitary adrenal) Axis may stand the test of time.

I have been reviewing books that deal with PTSD for many years and I can state that this is the first textbook that deals sufficiently with the treatment of PTSD in such a way that it can be used as an introduction for the novice and a learned review for those therapists who are refined with experience. It is a work that is useful for therapists who operate in remote locations that make regular supervision a dear commodity.

Over the years therapists evolve as new information comes into the profession after graduate school. Some may be forced to abandon systems in favor of new and more efficient techniques. They slip into specialties as a result of job opportunities and preferences. New wars provide clients who are young replicas of older clients still in treatment. John Briere and Catherine Scott have given us a book that will no doubt go through several editions. It will succeed because it gives us a philosophy that incorporates the changes in therapies and techniques as research drives the field. It is specific enough to be helpful, and flexible enough to be used by a variety of clinicians. Best of all, *Principles of Trauma Therapy* gives much deserved emphasis on the healing quality of the relationship between therapist and client so often left out of institutions that train and process large numbers of therapists and clients as a reason for being. ##

PTSD Casualties from Vietnam War Validated by Independent Research —Article in journal *Science* also addresses Iraq War veterans

In a news-making article in the weekly journal *Science* ["The Psychological Risks of Vietnam for U.S. Veterans: A Revisit with New Data and Methods," 8/18/2006, vol. 313, 979-982], Bruce Dohrenwend, Blake Turner, Nicholas Turse, Ben Adams, Karestan Koenen and Randall Marshall, of Harvard University, reexamined the data from the 1988 NVVRS (National Vietnam Veterans Readjustment Study). That study placed the lifetime PTSD casualty rate at 30.9%, whereas an earlier Centers for Disease Control study placed the lifetime PTSD rate for Vietnam War veterans at 14.7%. These percentages apply to the 2.15 million men who served in Vietnam during the war.

Dohrenwend, et al, summarize their approach: "We used data from military personnel files (201 files) extracted by the NVVRS investigators...together with data that were obtained from military archival sources and historical accounts to develop a record-based military historical measure (MHM) of probable severity of exposure to war-zone stressors that would capture this complexity [i.e., those who were exposed to combat versus those merely serving in Vietnam theater]. We constructed this MHM of exposure for all 1200 veterans in the NVVRS's representative sample of men who served in Vietnam or surrounding areas (Theater veterans)…. The first three components of the MHM are the veteran's military occupational specialty, the monthly killed-in-action rate in his larger military unit (e.g., division)…. We have combined…, validated…, and refined these three measures with important previously unused data from the military records of the approximately 58,000 U.S. servicemen killed in action in Vietnam…" (p. 979). (Ellipses in this and following quotations refer to references in the original article.)

As the authors explain, the original NVVRS sample consisted of 260 veterans from 28 metropolitan areas, conducting individual interviews by doctoral level interviewers. Dohrenwend, et al, reexamined the interviewers documents. "We conducted further analyses of these data because they shed light on the nature of PTSD and its prevalence in Vietnam veterans. Most important, on the basis of information contained in the written records and tape recordings of these diagnoses, we were able to distinguish (i) between war-related first onsets of PTSD and first onsets that occurred before or after service in Vietnam in calculations of lifetime rates and (ii) between past PTSD that remitted and current PTSD that was present in the six months before the diagnostic examinations…. We were also able to identify the types of criterion traumatic events that were reported by the veterans. The majority (86.6%) of the veterans with war-related onsets described events that our raters, blind to diagnostic status, judged to be personally life threatening. Events that involved witnessing death or physical harm to others were also frequently reported" (p. 980).

The authors then compared the veterans' statements with their MHM records to seek evidence of exaggeration or lying. They write, "Using questionnaire measures of dissembling…and self-reported symptoms, we found no indication of dissembling and little evidence of exaggeration…" (pp 980-981). Furthermore, they write that they found a so-called "dose-response relationship" (high exposure to combat producing a high rate of symptoms). "The relationship is especially strong for current PTSD, with less than 1% of the low-exposed veterans receiving this diagnosis, compared with 28.1% of the veterans in the very high exposure category" (p. 981).

Dohrenwend, et al, make a strong summary of their findings. "The message from NVVRS has been that the Vietnam War took a severe psychological toll on U.S. veterans. Our results provide compelling reasons to take this message seriously. The nature of this toll is suggested by the substantial rates of war-related onset and current PTSD and their strong dose-response relationship with severity of exposure—a relationship that cannot be due to biases in self reports of exposure because it holds for our new prospective, record-based MHM…. It is especially notable that, conservatively, almost 10% suffered from and were impaired by current PTSD more than a decade after the war. This finding points to the need for further research on the factors that contribute to chronicity…" (p. 982). Ten percent of 2.15 million is 215,000.

Dohrenwend, et al, conclude their article with something of an understatement, in applying the research findings to the current War on Terror. "Substantial similarities exist between Vietnam then and Iraq now. Both have been wars without fronts, in which it is often difficult to tell peaceful civilians from enemy combatants. What has been, and can still be, learned about PTSD and Vietnam veterans should be applicable to understanding the psychological risks to U.S. veterans of the war in Iraq" (p. 982).

Comment

It is important to put in perspective that the original NVVRS study was done in the 1980s. There is no reason, however, to think that the rates of chronic PTSD from Vietnam have dwindled. In fact, there is evidence from our own state experience that the current War on Terror have caused many Vietnam War veterans to seek help for the first time. If the 10% figure for *current* PTSD holds, then if we assume some 215,000 Vietnam War veterans receive on the average a 50% service connected disability, assuming also that those who have PTSD and have not applied or have been rejected, cancel out the veterans who do not have PTSD but have been granted a disability, that amounts to about $2.6 billion a year in disability compensation. Add to that the disabilities and treatment for lingering war wounds, diseases due to chronic stress, including diabetes, GERD and other GI problems, sleep apnea, obesity, heart disease, and arthritis, and we have a sense of what the war that ended over 30 years ago is costing this nation. It is left for us then to add in the PTSD and other service connected disabilities from the current War on Terror, which will linger on for many years after the guns have gone silent, to appreciate the long range cost of war on our nation. EE ##

Hope Restorer's Network—An interview with Dorothy Hanson

EE: I've been hearing a buzz about a group you are involved with. Tell me about it.
DH: Yes, Emmett, I'm very excited about this group, you must be referring to "Hope Restorer's Network."
EE: What exactly is "Hope Restorer's Network?"
DH: This is a group of highly talented and capable women who are committed to providing support, education, and hope to veterans and family members who have been impacted by combat trauma.
EE: How did this group come about? Was this your idea?
DH: One day I was talking with Carol, one of the women who I call the "founding mothers." She was talking about her challenges of living with a Vietnam War veteran for 38 years. She referenced the fact that she had no idea what PTSD was for a great portion of her marriage, often blaming herself for many of the struggles. She also acknowledged how useful it was for her to have information about PTSD and the idea of "if I only knew then what I know now." She went on to say how she would love to be able to help the partners and other family members of this most current war, so that they won't have to suffer in isolation. So this was not my idea, but I did jump on what I considered to be a great idea. The impact of this war on our society as a whole, is and will be, so big that the idea of one generation who has already been through this helping the next generation get through it will be part of the solution. So I began inviting other women I know who I believe could be an asset to this vision. All the women I contacted had the same positive attitude and also carry the shared belief that their personal struggles will not be for nothing if they are able to share their wisdom and hope with others. Many were brought to tears at the thought of contributing to society in this way.
EE: So, besides you, who makes up the members of this group?
DH: Actually, Emmett, I am not a member of this group, mainly because I don't meet the requirements to be a member. Although I am a veteran, to be a member of this group you must have lived with or are living with a combat vet who suffers or suffered with PTSD. Members are also at a point in their lives where they have addressed their own issues and progressed in their healing process to the point of being able to give back. My role with this group is to act as advisor, consultant, and liaison to organizations, and I screen potential new members for mental wellness. Eventually I envision that the core members will be so solid in their clarity and vision that my presence will become less and less frequent.

This is a very diverse group of women. They consist of widows, ex-wives, first wives, second wives, and daughters of combat veterans ranging from the Korean War to the war in Iraq. The women are professionals, housewives, stay-at-home moms, retirees, and graduate students. The core group was six women and I have recently interviewed three others who are joining the network.

EE: Tell me a little about what this group will be doing.
DH: At the time of this interview, the group has met twice. The focus of these meetings was to adopt a name which would fully express the intention and vision of the group, and to develop a mission statement. In addition to those two things which were accomplished, the women are developing clarity around how the work will be carried out and the range and scope of the mission.
EE: So could you explain the name and tell me what the mission statement is?
DH: The name "Hope Restorer's Network" represents the idea that these women, by tapping into their own wisdom and experiences around self-care, will restore hope in those family members of combat vets who have either lost hope or are having difficulties finding hope given their circumstances. The idea is that another generation of families should not have to go through years of ignorance around PTSD and how it impacts the family. It is a network because this is not a closed group. The vision is to branch out and touch as many people as possible providing resources and support. This will eventually be done by training others to do the same. The mission statement adopted by the group is "Providing hope, support, and resources for veterans and their family members affected by combat related experiences.
EE: How do you envision this mission being carried out?
DH: The Network members will speak to groups where family members meet, they will also connect with those who come in contact with military and veteran family members. A good example of that would be to go into schools and educate teachers and school counselors on what to look for in children who may be impacted by a parent's deployment or re-entry into the family. Other ways of getting the information out is to write articles for local newspapers and even being part of a DVD which is produced to educate vets and families. We also hope to have a Website. A couple of the members are working on that now. We are currently working on a pamphlet that can be handed out, which contains information on combat stress symptoms, resources, and tips on self-care. Again, the main focus is on sharing the wisdom of self-care for partners and other family members of vets and education on when to seek professional help.
EE: Thank you very much Dorothy, I look forward to hearing more about how this group progresses as time goes by. Is there anything else you would like to add?
Dorothy: Thank you for the opportunity to get the word out, Emmett. I think I'll end with the motto which has been adopted by the group: **"WE…are the ones we have been waiting for." Hopi Elders ##**

Dorothy Hanson, M.A., is a WDVA and King County Veterans Program contractor. See page 12 for details.

Tom's Intrusive Thoughts

WDVA Relocates Its Offices—A Chance to Reflect on Change

By Tom Schumacher

WDVA Relocates to New Headquarters in Olympia

For the past four years, WDVA has been located at two separate sites in Olympia. The Veteran Services Office and the PTSD Program resided about a block away from our Headquarters (HQ) - finance, personal, administration. Both locations suffered from a plethora of ills, including lack of space, no parking for visitors or staff, cold in winter and hot is summer, and on occasions, to quote a line from *O Brother, Where Art Thou?*, "A physical anomaly - two weeks from everywhere." People were constantly showing up at the wrong WDVA building.

Occupants of the two WDVA sites have now been liberated from their crowded quarters and have ventured down the street to our new digs at 1102 Quince Street SE. With the help of a phalanx of what might have been former Halliburton contractors, the actual move was accomplished over the space of two week's time. The new three floor building, complete with columns and flag poles, electronic entry systems, and state prison produced furniture, now houses all of the administrative, accounting, information services, human resources, veteran services, and our beloved PTSD treatment *management team*. The new building is so spacious that lost items are still lost, and some staff have been tucked away so well that the search for them has now gone into extra innings and includes pictures on milk cartons.

This move marks my fourth while in state government. Each of these involuntary treks within a two block area seems to demand more energy than the last to accomplish. Accumulated trauma journals, books, workshop presentations and contractor files have again undergone a sort of triage exercise — dispose, keep, or archive to the state repository, so that they can throw the items away in 7 to 10 years.

This housekeeping gave me a chance to measure the past four years in cubic feet of accumulate stuff. I found that I had literally amassed a one yard tall stack of articles just related to the current war, its impact upon our troops, and methods of outreaching and treating these recent combatants. One yard is a lot of material, and I have sorted it twice to reduce duplicated items.

Changes like this actually create new definitions of space, and disrupts one's rhythm. Ebb and flow become slosh and spill. Nothing in my routine feels automatic, and with all of the heavy lifting and stairways, my legs do not seem to function as they once did. Automatic movement has been replaced by a new element of conscious stepping— the loss of that all important kinetic knowing where one's feet have been, currently are, and may end up. All of this does conger up memories of deployments 37 and 38 years ago, and creates at least a small level of empathy for our state residents who are sent to Iraq and elsewhere for a year or more at a time. Just the deployment can be disorienting, and when you add hazards and death to the formula, we are talking life changing experiences. Not just a move down the block.

US House -Veterans Affairs Committee/Subcommittee Hearing—25 September 2006

In a hearing that was marked by frequent jabs by legislators, a squad of VA and US Army researchers testified at the Subcommittee on Health on the topics of PTSD and Traumatic Brain Injury (TBI). The hearing was held in order to obtain a more complete understanding of the PTSD and TBI levels of the current war theaters. Most well known among the expert witnesses were Charles Hoge, MD, Chief of Psychiatry, Division of Neuroscience, Walter Reed Army Institute of Research. Others included Gerald Cross, MD, Acting Deputy Under Secretary for Health, VA, and Col. Elspeth Ritchie, MD, Psychiatry Consultant to the US Army Surgeon General.

While very little was noted about TBI, there was grave concern expressed about the reported 78-100 OIF/OEF suicides. Members of the legislative committee noted they had heard the real number was in the hundreds. However the Army pressed the issue by saying they followed the 1-in-100 soldiers who reported on survey as having suicidal thoughts.

A quote attributed to Dr. Cross offered the following summary about PTSD: "About one-third of returning soldiers have received some form of mental health care, mostly preventative. About 12% of returning troops have been diagnosed with some form of mental health problem within the first year of returning home. Once veterans go into the VA system, the levels remain about the same. The VA sees about 30% of returning veterans, and about one third of those show some signs of PTSD. Initial evidence demonstrates that, of those exposed to significant trauma, about 25% will show display signs of PTSD. Most will recover on their own or with limited intervention. About 8-10% will require additional treatment, and about 60% of those will respond to therapy. It was also noted that due to lack of facility space in the military, the VA picks up many of the wounded and mental health service needs.

The pre– and post-deployment screening tools continue to be an issue in this Subcommittee hearing. The latest tools were claimed to have an 80% sensitivity to the soldier's symptoms, but the VA really does not use the survey for reasons that were not entirely clear. Other comments reported the Army's attempts to do more pre-trauma education and make unit leaders and commanders more sensitive to the needs of active duty personnel.

(Continued on page 10, See *Tom's Intrusive Thoughts*)

***Tom's Intrusive Thoughts*, Continued from page 9.**

Charles Hoge, MD, whom most readers will remember for the early study of returning OIF and OEF marines and soldiers, stressed the normality of having readjustment issues after serving long tours in a dangerous and unpredictable deployment. He noted the Army's encouragement for soldiers to not react to old stigmas about mental health care, and to seek trauma help early, before problems begin to affect soldiers' health. He noted that it is not uncommon for problems to appear months after returning, and that multiple screenings offer chances to discover these problems. He notes that 18% of soldiers receive care for mental health issues. Not well explained is the fact that he believes active duty soldiers experience fewer problems than do reserve unit members.

Dr. Richie added that education of the troops, as well as the use of chaplains, offered additional pathways for soldiers to seek care. She also said something that has rung true for us at the state level, namely, to create a method whereby there are many opportunities for the returning soldier to be offered counseling "to give them as many chances as possible."

Little was offered regarding TBI, and there were odd but hopeful comments about services being created for family members. This has not largely been the case in many areas of the country. Additionally, even though there were many promises made to continue to extend services to every veteran, and that there were sufficient funds to do this, Subcommittee members were very critical of the testimony, and said that "the statistics rendered really only reflect those veterans who actually come in." Further, "that reserve units (and perhaps they meant to say National Guard units) were not likely to check anything (on the surveys) that would delay them going home in two or three days." Representative Filner asserted that the witnesses "are unfairly constrained by their Secretaries from speaking freely…" (and he) "is very sure that they need more resources than they are admitting here."

National Guard MOU Drill Weekend Events

Tom Riggs, the National Guard (embedded) MOU Coordinator, continues to set up as many as possible of the Family Activity Days, Job Fairs, and information events on National Guard drill weekends. These have been successful at the task of identifying soldiers and families that need counseling services and other entitlements. Employers have come to find the events useful vehicles for discovering returning soldiers with skills as drivers, skilled electricians, and many other positions. Our rate of counseling referral continues to be relatively high, perhaps exceeding 40% in many cases. This is particularly true of those units who have not gone through a formal survey for months after returning, suggesting that there may be a kind of incubation of troubles occurring for some National Guard members secondary to the deployment to Iraq and elsewhere. The ever changing schedule for these events can be found by contacting me, or Tom Riggs at tom.riggs@us.army.mil or by telephone 253-512-8722. Tom Riggs is also the go-to person for benefits and referral help for National Guard and reserve members. Feel free to contact him if you are seeing a guardsman, guardswoman, or a family member who needs special assistance.

In the past few weeks, VAMC, Vet Center, and WDVA Contractors and staff have attended several of these important outreach events. Other contractors are welcome to "enlist" for these events, but this also needs to be coordinated through Tom Riggs and me. VAMC and Vet Center staff members usually also work through Tom Riggs.

On occasion we have had special requests for services with units that have undergone especially difficult combat. We are very pleased that these connections occur, which are often the result of Tom Riggs' efforts with the unit commanders. Thank you, Tom Riggs, you are peerless!

Update on King County Funding

For all of those contractors who are waiting final word about the King County "amended" and "augmented" services funding—WDVA continues to work with King County to resolve some last minute, but impeding, details. Last year King County passed a referendum that will eventually provide significantly more money for veterans services, including money for outpatient counseling. These funds are very much needed to address the needs of returning OIF and OEF combatants—veterans and family members who are in significant need of services now. The wait that we are currently enduring is the kind of challenge that purportedly builds "character"—hopefully not of the Axis II variety. We are now hopeful that the current contract can be amended sometime in October, and that next King County fiscal year (beginning in January 2007) our service funding levels will better match the needs. My only wish would be that other counties might see the wisdom of creating treatment and other support for OIF/OEF veterans and family members who need various types of help.

Journal of Traumatic Stress

Several of our Puget Sound Health Care System, Seattle (VAMC), mental health colleagues have recently had articles selected for publication in the ISTSS, *Journal of Traumatic Stress.* While not listing every name attached to the articles, most of you will recognize Matthew Jakupcak, Scott Michael, Miles McFall, and Tracy Simpson. Nice work! ##

ISTSS Meets in Hollywood

The stars of the International Society of Traumatic Stress Studies will meet in Hollywood, California, on November 3-7, 2006. Featured will be seminars, lectures, panels, and posters related to the research being conducted around the world where psychological trauma occurs. Details regarding the meeting registration and agenda can be found at www.istss.org. ##

Movie Review:

Hail the Conquering Hero—Fake war veteran elected mayor

Reviewed by Emmett Early

Movies about returning war veterans that were made during World War II were replete with small town hominess, moms in aprons, pipe smoking dads, and ethnic slurs. Preston Sturges made *Hail the Conquering Hero*, released in 1944, as a comedy incorporating all the clichés. The film features Eddie Bracken as a young man named Woodrow, who was rejected by the Marine Corps because of hay fever and discharged from boot camp. He has been working in a shipyard and is in a depressed mood as he sips his beer in a tavern, when in walk 6 marines back from Guadalcanal. The tavern is crowded with service men. The marines have only 15 cents between them, enough for only one beer. Woodrow buys them beer and sandwiches and the marines come over to hear his sad story. Woodrow tells them of his ignominious rejection by the USMC. He relates that he is the son of a WWI marine and has always wanted to become a marine. He proceeds to name all the battles the marines have had in their history to date. Turns out the master sergeant in the group was with Wooddrow's father when he was killed in Ballou Wood. Amazing coincidence. Another marine, a private and an orphan, is indignant when he learns that Woodrow has not told his mother of his sad story. She thinks he's overseas. The marines are hail fellows and push the passive Woodrow into posing as one of them just back. They call his mother and announce that he is returning home.

Sturges' *Hail the Conquering Hero* is fast and funny as the townspeople greet the hapless Woodrow as a hero, accompanied by his 6 marine buddies. We get the feeling that it was just as well Woodrow missed the battle for Guadalcanal, or it might have gone the other way.

Ella Raines plays Woodrow's former girlfriend, Libby. He had long ago called her to tell her he'd found another woman, so she is engaged to the mayor's son, Forrest. We find out that not only was Woodrow's dad a WWI Medal of Honor winner with a shrine in his mother's home, but his grandfather was a Civil War veteran who wore his uniform all his life.

The townspeople greet Woodrow, who arrives on the train in a borrowed uniform, with bands and banners. Sturges plays the crowd's antics for bald humor. In the spirit of the moment the real marines make up stories of Woodrow's heroism, and in the telling, their jingoistic ethnic slurs pour forth. The enemy are "Japs," "brown brothers," "nips," "ring tails."

Sturges plays the same jokes repeatedly with increasing humor. The tough orphaned marine becomes sappy around Woodrow's mom. Woodrow's hay fever sneezes get confused with his bogus jungle fever. Interestingly, Woodrow is portrayed as having a combat nightmare. The vet who is watching outside his door interrupts and tells him, "You're lucky you don't have 'em all the time like some guys."

The United States of America portrayed in Preston Sturges' *Hail the Conquering Hero* is entirely white, except for black railroad porters. Woodrow's Mom wears an apron and serves, yes, apple pie. It was an era when a young man had to defensively explain why he wasn't serving his country. Sturges portrays the people with a kind of loving populist humor, with the buffoon band director, the vain blowhard mayor, the good and faithful girlfriend in modest dress.

The idea of playing the war hero as political fodder is regarded differently these days after John Kerry's folly in the last election. When Woodrow finally does the right thing and confesses to the assembled citizens that he is a phony war veteran "not fit to reach as high as my father's footsteps," of course the townspeople love him all the more, and still want him to be their mayor. In the last scene we see the 6 marines riding off to their next battle, waving from the back of the train, and we are sure that Woodrow will win the election.

It is instructive to see films of the WWII era that are samples of popular appeal. They are illusory in their concept of the USA and censorious about the wartime legacy of psychological and physical damage. Sturges mocks the popular hunger for heroes and his style is to play the innocence mixed with buffoonery. We often compare WWII veterans with veterans of more recent wars, but we cannot duplicate the frame of reference—the citizens who get their censored war news from newspapers and radio, a government that does not broadcast bad news, such as the long-term casualties that war creates. The WWII illusion comes because there was no real political conflict about fighting. The enemy was defined and vilified as inferior beings. Men, mostly white, fought fair and bore their wounds with dignity. It was a time when the veterans came back from war, went to work, or enrolled in school, and got down to living the dream they fought for. Those kinds of illusions play poorly on today's news blitz.

The problem these days of this sort of illusion is that there are no more politically clean wars. War veterans are permanently marked by combat, despite the persisting myth that PTSD is overblown and a problem for only a small percentage of combat veterans. Americans wish that war is not damaging for the long term and that the war veteran with PTSD is an anomaly instead of a long term collective tax burden. Woodrow's worship of his father and his war veteran heritage is played for laughs in *Hail the Conquering Hero*, and to a certain extent we regard past wars and their veterans as mythical figures whose battles grow more fabulous with the telling, and to a certain extent we regard the current crop of war veterans as men and women who will have to bear their own the burden of memory. ##

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Director of the King County Veterans Program is Joel Estey.

King County Veterans Program, which also provides vocational counseling and emergency assistance, is located at 123 Third Ave. South, Seattle, WA….206 296 7656.

To be considered for service by a WDVA or King County contractor, a veteran or veteran's family member must present a copy of the veteran's discharge form DD-214 that will be kept in the contractor's file as part of the case documentation. Occasionally, other documentation may be used prove the veteran's military service. You are encouraged to call Tom for additional information.

It is always preferred that the referring person telephone ahead to discuss the client's appropriateness and the availability of time on the counselor's calendar. Contractors are all on a monthly budget, however, contractors in all areas of the state are willing to discuss treatment planning.

Some of the program contractors conduct both group and individual/family counseling. ##

VA Medical Centers and RCS Vet Centers with Washington State

Seattle Vet Center 206 553 2706	Yakima Vet Center 509 457 2736	Seattle Puget Sound Health Care
Tacoma Vet Center 253 565 7038	Spokane Vet Center 509 444 8387	System VAMC 206 762 1010
Bellingham Vet Center 360 733 9226	Spokane VA PTSD Program 509 434 7013	
Seattle VA Deployment Clinic 206 764 2636	Portland/Vancouver VAMC 503-273-5058	Portland VC 503-273-5370

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